Child Death Review/
Citizen's Review Panel Descriptions

(1) Local Child Death Review (CDR) Teams:

The Child Protection Law (MCL 722.627b) requires each county in Michigan to have a standing child fatality review team. The Michigan Child Death Review (CDR) program supports the voluntary, multidisciplinary child death review teams in all 83 counties of Michigan. The local teams are comprised of approximately 1,200 professionals, who meet regularly to review the circumstances surrounding the deaths of children in their communities.

The average team is comprised of 15 members and includes, at a minimum:

- the county prosecutor or designated assistant prosecutor.
- a representative of a state, county and/or local law enforcement.
- a representative from DHS.
- a representative form local public health or community health.
- the county medical examiner or deputy medical examiner.

Additional membership may also include emergency medical personnel, mental health, education, pediatricians, hospital staff, other human service providers or key community leaders. Teams have discretion in selecting their coordinator, team membership and operating procedures. As teams have matured over the past 13 years, most have evolved from a focus on investigation and data collection to converting their findings into action to prevent deaths. From the program's inception, teams have reviewed over 7,800 child deaths. Local teams have recommended over 1,300 strategies to prevent deaths and have taken action at the local level to implement almost 1,000 of these, to help prevent future child deaths.

(2) Child Death State Advisory Team:

Child Protection Law also created a state level team of professionals to "identify and make recommendations on policy and statutory changes pertaining to child fatalities, and to guide statewide prevention, education and training efforts." This Child Death State Advisory Team has met quarterly since 1998. The director of DHS selects members, with no term limits established. The law requires representation from DHS, MDCH, law enforcement, a county prosecuting attorney, a county medical examiner and the Children's Ombudsman or designee. Other members have been appointed to add expertise related to cause and prevention of child death. DHS chairs the meetings, which generally includes review of local CDR findings and current state level issues affecting the health, safety and protection of children, presentations by state experts on topics related to child health and safety, and development of recommendations for the annual report.

(3) Citizen Review Panel on Child Fatalities:

In 1996, it was mandated that states receiving federal Child Abuse Prevention and Treatment Act (CAPTA) funding were to establish three "Citizen Review Panels" (CRP). The CRPs were required to focus on (1) child fatalities, (2) foster care and adoption services and (3) child abuse prevention services. As noted above, in 1999, it was determined that the Child Death Review State Advisory Team would serve as the state's federally mandated CRP on Child Fatalities. This sub-committee meets regularly to conduct in-depth retrospective case reviews of children who have died and his/her family was involved in the child protection

system, either at the time of death or historically. These reviews utilize documentation from DHS, law enforcement, medical care providers (including autopsies) and any additional information that applies. The team is responsible for developing systems level recommendations and completing an annual report. The CRP believes that multidisciplinary action is required to fully protect children, therefore, recommendations are made to all professions within the child protection system, including law enforcement, medical care providers, education and the courts.

Department of Human Services
Notified of Child Death
Via CPS Complaint

Child Death Alerts to:

- DHS Administration
- Michigan Public Health Institute
- Office of Children's Ombudsman

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(1) 83 Local CDR Teams
[CPL Sec 7b]
Local multidisciplinary teams complete individual case review

(2) Child Death State Advisory Team
[CPS Sec 7b]
Multidisciplinary team completes aggregate review of statistics

(3) Citizen's Review Panel
[CAPTA 106(b)(2)(A)(x)]
Multidisciplinary team completes in-depth retrospective case review

Annual Report provided to Governor and Standing Committees* of Legislature

Annual Report provided to DHS

*Committees with jurisdiction over matters pertaining to child protection.

Child Death Reviews in Michigan

Jennifer M. Granholm, Governor
Ismael Ahmed, DHS Director

Department of Human Services notified of child death via CPS complaint

Child Death Alerts to:

- DHS Administration
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DEPARTMENT OF HUMAN SERVICES

(1) Local Child Death Review (CDR) Teams:

- Legal basis: Child Protection Law (MCL 722.627b).
- All 83 counties in Michigan.
- Multidisciplinary and voluntary.
- Supported by the Michigan Child Death Review (CDR) program.
- Approx. 1,200 professionals meet regularly to review the circumstances of death of children in their communities.

Local CDR Teams, cont'd

The average CDR team has 15 members and includes, at a minimum:

- Prosecutor or designated assistant prosecutor.
- Representative of state, county and/or local law enforcement.
- Representative of DHS.
- Representative of local public health or community health.
- County medical examiner or deputy medical examiner.

Local CDR Teams, cont'd

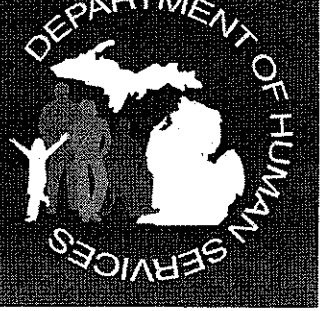
Additional members may include:

- Emergency medical personnel.
- Mental health.
- Education.
- Pediatricians.
- Hospital staff.
- Other human service providers or key community leaders.

Local CDR Teams, cont'd

Teams select their coordinator, team membership and operating procedures. As teams have matured over the past 13 years, most have evolved from a focus on investigation and data collection to converting their findings into action to prevent deaths. From the program's inception, teams have:

- Reviewed over 7,800 child deaths.
- Recommended over 1,300 strategies to prevent deaths.
- Locally implement almost 1,000 of these strategies.



(2)Child Death State Advisory Team:

- Legal basis: 1998, Child Protection Law, to "identify and make recommendations on policy and statutory changes pertaining to child fatalities, and to guide statewide prevention, education and training efforts."
- Meets quarterly.
- Director of DHS selects members.
- No term limits.
- Reviews local CDR findings and current state level issues.
- Presentations by state experts.
- Development of recommendations for the annual report.

Child Death State Advisory Team, cont'd

The law requires representation from:

- DHS, chair of team.
- MDCH.
- Law enforcement.
- County prosecuting attorney.
- County medical examiner.
- Children's Ombudsman or designee.
- Other members appointed to add expertise.

(3)Citizen Review Panel on Child Fatalities

- Legal basis: 1996, federal Child Abuse Prevention and Treatment Act (CAPTA), to establish three "Citizen Review Panels" (CRP).
- CRPs required to focus on
  - Child fatalities.
  - Foster care and adoption services.
  - Child abuse prevention services.

Citizen Review Panel on Child Fatalities, cont'd

In 1999, the Child Death Review State Advisory Team began serving as the CRP on Child Fatalities. CRP:

- Regularly conducts retrospective child death case reviews if their family was involved with CPS, at the time of death or historically.
- Utilizes records from DHS, law enforcement, medical providers (including autopsies) and any other information that applies.
- Develops systems level recommendations and an annual report.
- Recommendations are made to all professions in the child protection system, including:
  - Law enforcement.
  - Medical care providers.
  - Education.
  - The courts.